



Children's Extensive Support  
1115 (a) Demonstration Waiver Request

A Waiver Request Submitted under the Authority of  
**Section 1115 (a) of the Social Security Act**

to

**Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Service**

**July 01, 2003**

## TABLE OF CONTENTS

	<u>Page Number(s)</u>
Executive Summary	1
Public Notice	2
Input from public agencies	3
Environment	3
Program Administration	3
Program Eligibility	4
Benefit Package	7
Delivery System	10
Quality Assurance	10
Recipient Appeals	11
System Support	11
Financial Issues	11
Implementation Time Frames	11
Evaluation and Reporting	11
Waivers	12
<u>Attachments</u>	
ULTC-100.2	
Waiver Cost Estimates Attachments F-1 through F-6	

## **SECTION 1115(a) RESEARCH AND DEMONSTRATION**

### **WAIVER APPLICATION**

#### **COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

##### **I. Executive Summary**

The Colorado Department of Health Care Policy and Financing (HCPF) is requesting a Section 1115(a) demonstration waiver for a period of five (5) years to impose cost sharing requirements on families of children who meet eligibility requirements for Colorado's 1915(c) Children's Extensive Support (CES) waiver (waiver # 4180.90.01) whose family income exceeds 300% of the federal poverty level. The proposed implementation date of this waiver is July 1, 2003.

The following describes the key components of the proposed program:

- A. Children who meet the targeting criteria approved for the 1915(c) CES waiver but who are not categorically eligible shall be eligible for enrollment in the 1115(a) CES demonstration waiver.
- B. Colorado's State Plan Benefits are not incorporated into this waiver. However, children enrolled in the 1115(a) CES demonstration waiver shall continue to have access to those benefits, as they have under the 1915(c) waiver.
- C. Families of enrolling or enrolled children will be required to keep their existing insurance.
- D. Families of enrolling or enrolled children who deliberately decline or terminate existing or readily available employer-based health insurance coverage shall be subject to recovery of medical assistance payments as applicable. Additionally, families shall be assessed a 10% increase in monthly premium fees.

- E. Families of enrolling or enrolled children who lose their private health insurance coverage due to any other reason, including but not limited to loss of employment or unavailability of health insurance shall not be subject to recovery of medical assistance payments.
- F. The monthly premium fee shall be a sliding fee scale with a maximum fee of \$250 per month for the first enrolled child and no more than \$50 per month for any additional child on the waiver.
- G. The monthly premium fee shall be based on the total income of the custodial parent(s) as reflected on the most recently filed Internal Revenue Service Federal Tax Return. Documentation shall include any late or amended returns.
- H. The number of children served will be limited to the number of children who are not categorically eligible and have been allocated a CES resource. This number served in this demonstration waiver when combined with the number served in waiver # 4180 shall not exceed 212 full year equivalents or the number of resources allocated by the legislature.
- I. The Department of Human Services/Division for Developmental Disabilities shall administer this waiver under the direction of the Single State Medicaid Agency, HCPF.

## **II. Public Notice**

Public notice has been provided through the following avenues:

- A. The legislative hearing process that resulted in the passage of Senate Bill 03-259.
- B. The publication of proposed rules on HCPF, Medical Services Board web site.
- C. Comments and letters from families, private providers, and advocate groups presented at the Medical Services Board hearing on June 13, 2003.
- D. State Administrative staff met with the children's advocacy group to discuss the issues related to this legislation.

### **III. Input from Public Agencies/Advocates**

A group, including parents of children enrolled in the 1915(c) CES waiver and advocates, proposed the monthly premium fee to HCPF. Due to the increasing pressure on the state's budget, the families and advocates felt the implementation of a premium fee was reasonable if it reduces the risk of the waiver's termination.

### **IV. Environment**

#### **A. Overview of Current System**

The children to be enrolled in this waiver are currently enrolled in Colorado's 1915(c) Children's Extensive Support Waiver (#4180.90.01). The legislative requirement to charge a premium fee that exceeds the amount allowable under federal regulations to families whose income exceeds 300% of the Federal Poverty Level requires the 1115(a) waiver authority to ensure continued services for these children.

#### **B. Experience with State Waivers**

Colorado currently has approval to operate nine different waivers. The 1915(c) CES waiver was initially approved in 1995. CMS's review did not reveal any substantive issues. The 1115(a) waiver request mirrors the 1915(c) waiver.

#### **C. State Budget**

Premium fees are expected to offset other sources of state funds and reduce stress on the state's budget.

### **V. Program Administration**

The demonstration waiver will be administered by the Department of Human Services/Division for Developmental Disabilities under the oversight of the Single State Medicaid Agency, HCPF.

The existing targeting criteria, except for categorical eligibility, the available services and supports and the administration of the 1115(a) demonstration waiver will remain the same as the current 1915(c) CES waiver.

## **VI. Program Eligibility**

- A. Children who meet all of the following program eligibility requirements will be determined eligible provided the individual can be served within capacity units in the approved waiver and available appropriations:
- 1) The child has not reached his/her 18<sup>th</sup> birthday; and
  - 2) The child is living at home with his/her biological, adoptive parent(s) or guardian, or is in an out-of-home placement including an ICF/MR, hospital or nursing facility and can be returned home with the provisions of CES services; and
  - 3) The child, if age five or older, has a developmental disability, or if less than five years of age, has a developmental delay, as determined by a Community Centered Board (CCB); and
  - 4) The child does not receive SSI but has been determined to be disabled according to SSI disability criteria through HCPF contractor for disability determinations; and
  - 5) The quality and quantity of medical services and supports identified in the Individualized Plan (IP) are provided pursuant to a physician's order to meet the needs of the child in the home setting; and
  - 6) The income of the child shall not exceed 300% of the current maximum SSI allowance; and
  - 7) The resources of the child shall not exceed the maximum SSI allowance; and
  - 8) Enrollment of a child in CES shall result in an overall savings when compared to the ICF/MR cost as determined by the State; and
  - 9) The Utilization Review Contractor (URC) certifies that the child meets the Level of Care for ICF/MR placement; and
  - 10) The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, re-direction or brief observation of medical status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

- a. A significant pattern of self-endangering behavior(s) or medical condition which, without intervention will result in a life threatening condition/situation. Significant pattern is defined as a behavior or medical condition that is harmful to self or others, is evidenced by actual events, and the events occurred within the past six months; or
  - b. A significant pattern of serious aggressive behaviors toward self, others or property; or
  - c. Constant vocalizations such as screaming, crying, laughing, or verbal threats that cause emotional distress to family caregivers. "Constant" is defined as an occurrence on average of fifteen (15) minutes of each waking hour.
- 11) The above conditions shall be evidenced by parent statement/data that is corroborated by written evidence that:
- a. The child's behavior(s) or medical need(s) have been demonstrated, or
  - b. In the instance of an annual reassessment, it can be established that in the absence of the existing interventions or preventions provided through the CES waiver that the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.
  - c. Examples of acceptable evidences shall include but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology Clinic reports, police reports, social services reports, or observation by a third party on a regular basis
- 12) The child must receive at least one waiver service each month.

A. Payment of Premiums

HCPF is authorized to collect monthly premiums from the families. Premiums will be determined annually based on 300 percent of the federal poverty level for the size of the family. Any income changes must be reported in order to recalculate the monthly premium fee. Families that have not paid their premium are subject to collections and/or garnishment of wages. If a family premium is in arrears, the child remains eligible for services.

The amount of the premium will be based on the custodial parent(s) total income as reported on the applicable Federal Income Tax Return is.

Attached is the fee schedule for two adults and one child per the 2003 Federal Poverty Guidelines:

Percent of Federal Poverty Guideline	Monthly Premium
Under 300%	\$0
300% to 349%	\$42
350% to 399%	\$83
400% to 449%	\$104
450% to 499%	\$125
500% to 549%	\$167
550% to 599%	\$208
600% +	\$250

For families with two or more enrolled children whose monthly premium fee for one enrolled child is fifty dollars or less, the amount of the monthly premium for each additional child shall not exceed the amount charged for the first child.

For families with two or more enrolled children whose monthly premium fee for one enrolled child is greater than fifty dollars, the amount of the monthly premium fee for each additional child shall be fifty dollars.

Unpaid monthly premium fees will be collected through a collection agency or private counsel. The unpaid monthly premium fee may also be collected by means of intercepting a family's state income tax refund or the garnishment of wages and other earnings.

For late or amended tax returns that result in an increased premium payments, the increase shall be retroactive to the date that the initial return would have been due in the absence of an extension.

#### B. Terminated Health Insurance Coverage

HCPF may recover Medicaid payments from a family who terminates or declines existing or readily available employer-based health insurance coverage for the sole purpose of avoiding multiple monthly premium payments for a child enrolled in the CES waiver.

A family shall not be subject to recovery of medical assistance payments if the loss of private health insurance coverage is due to any other reason, including but not limited to loss of employment or unavailability of health insurance for the enrolled

child. Once it has been determined that a family intentionally terminated or declined primary health insurance coverage, notwithstanding the monthly premium fee limitation, the family's monthly premium fee shall be increased by ten percent.

C. Level of Care:

The child must meet the level of care described at 42 CFR 441.302 (3) (c) or be at risk for institutional placement within 30 days. A copy of the Long Term Care Assessment tool (ULTC-100.2) is attached to this application.

## **VII. Benefits Package**

A. Medicaid State Plan Benefits

Children enrolled in this demonstration waiver will continue to have access to the full range of state plan benefits.

B. 1115(a) Services

The State requests that the following services, as described and defined herein, be included under this waiver:

Services available under the 1115(a) Children's Extensive Support Waiver are only those services not otherwise available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage, or other state funded programs, services or supports.

1. Personal Assistance Services

- a. Childcare services include the temporary care of a child that is necessary to keep the child in the home and avoid institutionalization.
- b. Personal supports may include assistance with bathing and personal hygiene, eating, dressing and grooming, bowel and bladder care, menstrual care, transferring, basic first aid, giving medications, operating and maintaining medical equipment for a child who cannot perform these functions alone due to the developmental disability or medical condition.
- c. Household services includes assistance in performing housekeeping tasks which, due to the needs of the child with a developmental disability, are above and beyond the tasks generally required in a home and/or increase the parent(s) ability to provide care needed by the child with a developmental disability.

2. Environmental Engineering maximum Benefit is limited to \$10,000 per person for the current waiver span except on a case-by-case basis the state may authorize additional funds.

- a. Home Modification Services may include those services which assess the need for, arrange for and provide modifications and/or improvements to the family home of a child with a developmental disability to help ensure the child's safety, security and accessibility in the home and community. Home modifications services include devices and services to make daily living easier, such as adapted showers or toilets, adaptations that make places accessible such as ramps and railings and reinforcing or fencing for the child's protection. Services shall exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable state or local building codes.
- b. Assistive technology services may include the evaluation of the child's need for assistive technology related to the disability, helping to select and obtain appropriate devices, designing, fitting and customizing those devices, purchasing, repairing or replacing the devices, and training the child and/or family to use the devices effectively.

Assistive technology services include devices and services that will help a child with a developmental disability and the child's family to overcome barriers related to the disability that they face in their daily lives. This may include the use of devices to help children move around such as wheelchairs, wheelchair adaptations, and adaptations for vans (e.g., lifts for vans or roof storage for wheelchairs), devices that help the child communicate such as electronic communication devices (excluding cell phones, pagers, and internet access unless prior authorized by the state) devices that make learning easier such as adapted games, toys or computers and devices that control the environment such as switches.

- c. Recreational equipment, such as, a floatation collar for swimming, a bowling ramp, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a child with a developmental disability.

3. Specialized Equipment and Supplies:

- a. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods.
- b. General care items such as distilled water for saline solutions, supplies such as eating utensils, etc., required by a child with a developmental disability and related to the disability.

- d. Specially designed clothing (e.g. velcro) for children if the cost is over and above the costs generally incurred for a child's clothing.

#### 4. Professional Services

Professional services will be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, other third party liability coverage or other federal or state funded programs, services or supports.

- a. Individual and/or group counseling, behavioral or other therapeutic interventions related to the child's disability, needed to sustain the overall functioning of the child with a developmental disability.
- b. Consultation and direct service costs for training parents and other care providers in techniques to assist in caring for the child's need. Includes acquisition of information for family members of children with developmental disabilities from support organizations and special resource materials, (e.g., publications designed for parents of children with developmental disabilities.)
- c. Diagnostic, evaluation and testing services necessary to determine the child's health and mental status and the related social, psychological and cognitive needs and strengths, including genetic counseling and family planning.
- d. Professional care services are any personal care functions requiring assistance by an RN, LPN, Certified Nurse Aide or Home Health Aide and not otherwise available under Medicaid EPSDT coverage, third party liability coverage, or other state funded programs, services or supports. These services may also include operating and maintaining medical equipment.

#### 5. Community Connection Services

- a. The Community Connector will explore community services appropriate to the individual in their community, natural supports available to the individual, match and monitor community connections to enhance socialization and community access capability.
- b. Recreational programs that will allow the child with a developmental disability to experience typical community leisure time activities increase

their ability to participate in these activities and develop appropriate physical and psychological-social skills. (Limited to \$500 per year).

### **VIII. Delivery System**

All waiver services will be delivered through a network of enrolled Medicaid providers.

Reimbursement for waiver services provided will be a fee for service system.

### **IX. Quality Assurance**

The monitoring of the services provided under this demonstration waiver shall be the responsibility of the Department of Human Services/Division for Developmental Disabilities (DDD) under the direction of the HCPF.

DDD shall conduct on-sight surveys of each agency providing services under the 1115(a) CES Waiver. The surveys will include a review of applicable rules and standards developed for programs serving individuals with developmental disabilities and the review of Program Quality Manual (September 2000) issued by the DDD.

DDD shall ensure that the case management/CCB's fulfill its responsibilities in the following areas: development of the individualized plan, case management, monitoring of programs and services, and provider compliance with the assurances required of this program.

In accordance with federal regulations, DDD shall maintain a complete file of all records, documents, communications, and other materials that pertain to the operation of this program.

DDD shall recommend to HCPF the denial and/or termination of the Medicaid Provider Agreement for any agency that it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to DDD within the prescribed period of time or does not sufficiently fulfill the requirements of the corrective action plan within the prescribed period of time.

After having received the denial and/or termination recommendation and reviewing the supporting documentation, HCPF will take the appropriate action.

### **X. Recipient Appeals**

Recipients shall have access to the regular Medicaid appeals process identified in section 10 CCR 2505-10, section 8.057. Additionally recipients shall have access

to the informal local dispute resolution process identified in the Department of Human Services rules at 16.300. The formal appeal process complies with 42 CFR Part 431, Subpart E.

#### **XI. Systems Support**

The Medicaid Management Information System (MMIS) continues to document recipients and pay claims for services provided.

#### **XII. Financial Issues**

See Attachments F-1 through F-6.

#### **XIII. Implementation Time Frames**

The proposed effective date for implementation of the Colorado CES 1115(a) Demonstration Waiver Program is July 1, 2003.

#### **XIV Evaluation and Reporting**

The evaluation will be based on two objectives:

- A. Cost neutrality, and
- B. Access to quality care

#### **XV. Waivers**

The following waivers are requested for this demonstration.

- A. Section 1916(a)(2)(A) – Cost Sharing
- B. Section 1902(a)(1) – Statewideness
- C. Section 1902(a)(10)(B) – Amount Duration and Scope

Date Referral Completed: _____ Month/Day/Year	Screening Agency: _____	Screener Name: _____
Assessing Agency: _____ Assessor Name: _____	Provider #: _____	Worker #: _____

## ULTC 100.2 – INITIAL SCREENING AND INTAKE

Current Living Situation		
<input type="checkbox"/> Alone <input type="checkbox"/> With Spouse/ Others <input type="checkbox"/> With Non-Spouse Relatives <input type="checkbox"/> With Parents	<input type="checkbox"/> With Non-Relatives <input type="checkbox"/> Alternative Care Facility <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Pending Nursing Facility Discharge or Admission <input type="checkbox"/> Hospital Discharge, Date: _____ <input type="checkbox"/> DD Residential Program <input type="checkbox"/> ICF/MR

☐ **URGENT**

Applicant Information			
State ID: _____	Primary Language: _____	County ID: _____	
Last Name: _____	First Name: _____	Middle Initial: _____	SSN: _____
Address: _____	DOB: _____ Month/Day/Year	Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	
City: _____	State: _____	Zip: _____	Phone: _____

Presenting Problems and Diagnoses
Comments: _____

Areas of Concern			
<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Eating	<input type="checkbox"/> Toileting <input type="checkbox"/> Transferring <input type="checkbox"/> Mobility	<input type="checkbox"/> Behaviors <input type="checkbox"/> Memory/Cognition	<input type="checkbox"/> Possible Mental Illness <input type="checkbox"/> Possible Developmental Disability <input type="checkbox"/> Brain Injury

Potential Community Based Long Term Care Programs	
<input type="checkbox"/> HCBS-Elderly, Blind and Disabled (EBD) <input type="checkbox"/> Home Care Allowance (HCA) <input type="checkbox"/> Private Case Management <input type="checkbox"/> Long Term Skilled Home Health <input type="checkbox"/> PACE <input type="checkbox"/> HCBS-Children's Extensive Support (CES) <input type="checkbox"/> HCBS-Supported Living Services (SLS)	<input type="checkbox"/> HCBS-Persons Living with HIV/AIDS (PLWA) <input type="checkbox"/> HCBS-Brain Injury (BI) <input type="checkbox"/> HCBS-Mentally Ill (MI) <input type="checkbox"/> HCBS- DD (Comprehensive Services) <input type="checkbox"/> Consumer Directed Attendant Support (CDAS) <input type="checkbox"/> Children's HCBS <input type="checkbox"/> Other Program (specify): _____
<input type="checkbox"/> Medical information page sent to provider.	

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Residential Alternatives

- ☐ Adult Foster Care  
☐ Alternative Care Facility  
☐ DD Residential Program

- ☐ Nursing Facility  
☐ Other: \_\_\_\_\_  
☐ ICF/MR

### Information and Referral Provided

- ☐ Home Health  
☐ Vocational Rehabilitation  
☐ Community Centered Board  
☐ Homeless Shelter  
☐ Area Agency on Aging  
☐ Child Protection  
☐ Hospice

- ☐ Mental Health Services  
☐ Veterans Affairs  
☐ Adult Protective Services  
☐ County Eligibility  
☐ Community Food Bank  
☐ Other: \_\_\_\_\_

### Contact Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Comments: \_\_\_\_\_

### Referral Information

Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Organization/  
 Relationship: \_\_\_\_\_

### Financial Information

Client Income Source(s)		Spouse Income Source(s)	
Source	Amount	Source	Amount
<input type="checkbox"/> SSA/SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> OAP <input type="checkbox"/> AND/AB <input type="checkbox"/> Other: _____		<input type="checkbox"/> SSA/SSDI <input type="checkbox"/> SSI <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> OAP <input type="checkbox"/> AND/AB <input type="checkbox"/> Other: _____	
Gross Monthly Income	\$ _____	Gross Monthly Income	\$ _____
Assets:	\$ _____	Assets:	\$ _____

### Insurance Information

#### Client's Insurance Information

- ☐ VA Benefits  
☐ Medicare Part A  
☐ Medicare Part B  
☐ Private Health Insurance: \_\_\_\_\_  
☐ Medicaid  
☐ LTC Medicaid  
☐ Medicaid Pending  
☐ Application in Process

### Medical Provider Information

Provider Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Type of Provider: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

<input type="checkbox"/> Application Needed <input type="checkbox"/> Application Mailed Date: _____	Comments:
Comments:	

Case Assigned to: (worker name or number): \_\_\_\_\_ Date: \_\_\_\_\_

### Long Term Care Professional Medical Information

**Dear Medical Provider:**

**We are conducting a functional assessment of this person for long-term care services. The services will be provided in a skilled nursing facility, alternative care facility or in their own home in the community. Please complete the information below to help with the care planning for this person.**

**Client:**

Last Name: _____	First Name: _____	Middle Initial: _____
Street Address _____ City _____ State _____ Zip _____		
Date of Birth _____	Telephone _____	Male <input type="checkbox"/> Female <input type="checkbox"/>

### Medical Information Section:

ICD 9 Code	ICD 9 Description	Onset	Medication Name	Dosage	Frequency	Route

Other Services Required for Medical Problems: (oxygen therapy, patient education, monitoring, follow-up care):

Is there a Mental Health Diagnosis? Yes ☐ No ☐

Is there a Developmental Disability Diagnosis? Yes ☐ No ☐

Is there a Traumatic Brain Injury Diagnosis? Yes ☐ No ☐

Diagnosis of dementia must be validated by a neurological exam with documentation by the attending physician.

Neurological Exam Date: \_\_\_\_\_

If Hospitalized, Reason: _____  Diet Order: _____ Allergies: _____ Prognosis: _____	Admit Date: _____
--	----------------------

Medical Provider Name: _____	Address: _____
City: _____	State: _____ Zip: _____

Name of Person Completing this Information \_\_\_\_\_

Title: \_\_\_\_\_

Medical Provider Comments:

### Facility/Case Manager Information

Facility/Case Management Agency: \_\_\_\_\_

Administrator/Case Manager Name (print): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Administrator/Case Manager Signature: \_\_\_\_\_

## LONG TERM CARE ELIGIBILITY ASSESSMENT

**General Instructions:** To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.

### ACTIVITIES OF DAILY LIVING

#### I. BATHING

**Definition:** The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

#### ADL SCORING CRITERIA

☐0=The client is independent in completing the activity safely.

☐1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.

☐2=The client requires hands on help or standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.

☐3=The client is dependent on others to provide a complete bath.

**Due To: (Score must be justified through one or more of the following conditions)**

#### Physical Impairments:

- ☐Pain
- ☐Visually Impaired
- ☐Limited Range of Motion
- ☐Weakness
- ☐Balance Problems
- ☐Shortness of Breath
- ☐Decreased Endurance
- ☐Falls
- ☐Paralysis
- ☐Neurological Impairment
- ☐Oxygen Use
- ☐Muscle Tone
- ☐Amputation

☐Open Wound

☐Stoma Site

#### Supervision:

☐Cognitive Impairment

☐Memory Impairment

☐Behavior Issues

☐Lack of Awareness

☐Difficulty Learning

☐Seizures

#### Mental Health:

☐Lack of Motivation/Apathy

☐Delusional

☐Hallucinations

☐Paranoia

Comments:

#### II. DRESSING

**Definition:** The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

#### ADL SCORE CRITERIA

☐0= The client is independent in completing activity safely.

☐1=The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.

☐2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.

☐3= The client is totally dependent on others for dressing and undressing

**Due To: (Score must be justified through one or more of the following conditions)**

<b>Physical Impairments:</b> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Open Wound	<b>Supervision:</b> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <b>Mental Health:</b> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
---	---

**Comments:**

### III. TOILETING

**Definition:** The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

#### ADL SCORE CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.

☐2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean.

☐3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens.

This may include total care of catheter or ostomy. The client may or may not be aware of own needs.

**Due To: (Score must be justified through one or more of the following conditions)**

<b>Physical Impairments:</b> <input type="checkbox"/> Pain <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Physiological defect <input type="checkbox"/> Balance <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Impaction	<input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <b>Supervision Need:</b> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <b>Mental Health:</b> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
---	--

**Comments:**

#### IV. MOBILITY

**Definition:** The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment.

##### ADL SCORE CRITERIA

- ☐0=The client is independent in completing activity safely.
- ☐1=The client is mobile in their own home but may need assistance outside the home.
- ☐2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.
- ☐3=The client is dependent on others for all mobility.

**Due To: (Score must be justified through one or more of the following conditions)**

<b><u>Physical Impairments:</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/>Pain</li><li><input type="checkbox"/>Sensory Impairment</li><li><input type="checkbox"/>Limited Range of Motion</li><li><input type="checkbox"/>Weakness</li><li><input type="checkbox"/>Shortness of Breath</li><li><input type="checkbox"/>Decreased Endurance</li><li><input type="checkbox"/>Fine or Gross Motor Impairment</li><li><input type="checkbox"/>Paralysis</li><li><input type="checkbox"/>Neurological Impairment</li><li><input type="checkbox"/>Amputation</li><li><input type="checkbox"/>Oxygen Use</li><li><input type="checkbox"/>Balance</li><li><input type="checkbox"/>Muscle Tone</li></ul>	<b><u>Supervision Need:</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/>Cognitive Impairment</li><li><input type="checkbox"/>Memory Impairment</li><li><input type="checkbox"/>Behavior Issues</li><li><input type="checkbox"/>Lack of Awareness</li><li><input type="checkbox"/>Difficulty Learning</li><li><input type="checkbox"/>Seizures</li><li><input type="checkbox"/>History of Falls</li></ul> <b><u>Mental Health:</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/>Lack of Motivation/Apathy</li><li><input type="checkbox"/>Delusional</li><li><input type="checkbox"/>Hallucinations</li><li><input type="checkbox"/>Paranoia</li></ul>
---	--

**Comments:**

#### LONG TERM CARE ELIGIBILITY ASSESSMENT: ADLS (continued)

#### V. TRANSFERRING

**Definition:** The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices for transfers. Note: Score client's mobility without regard to use of equipment.

##### ADL SCORE CRITERIA

- ☐0=The client is independent in completing activity safely.
- ☐1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.
- ☐2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.
- ☐3=The client requires total assistance for transfers and/or positioning with or without equipment.

**Due To: (Score must be justified through one or more of the following conditions)**

<b><u>Physical Impairments:</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/>Pain</li><li><input type="checkbox"/>Sensory Impairment</li><li><input type="checkbox"/>Limited Range of Motion</li><li><input type="checkbox"/>Weakness</li><li><input type="checkbox"/>Balance Problems</li><li><input type="checkbox"/>Shortness of Breath</li><li><input type="checkbox"/>Falls</li><li><input type="checkbox"/>Decreased Endurance</li><li><input type="checkbox"/>Paralysis</li><li><input type="checkbox"/>Neurological Impairment</li><li><input type="checkbox"/>Amputation</li><li><input type="checkbox"/>Oxygen Use</li></ul>	<b><u>Supervision Need:</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/>Cognitive Impairment</li><li><input type="checkbox"/>Memory Impairment</li><li><input type="checkbox"/>Behavior Issues</li><li><input type="checkbox"/>Lack of Awareness</li><li><input type="checkbox"/>Difficulty Learning</li><li><input type="checkbox"/>Seizures</li></ul> <b><u>Mental Health:</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/>Lack of Motivation/Apathy</li><li><input type="checkbox"/>Delusional</li><li><input type="checkbox"/>Hallucinations</li><li><input type="checkbox"/>Paranoia</li></ul>
---	---

**Comments:**

## VI. EATING

**Definition:** The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. *Note: If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist.*

### ADL SCORE CRITERIA

- ☐0=The client is independent in completing activity safely
- ☐1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.
- ☐2=The client can feed self but needs standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.
- ☐3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

**Due To: (Score must be justified through one or more of the following conditions)**

#### **Physical Impairments:**

- ☐Pain
- ☐Visual Impairment
- ☐Limited Range of Motion
- ☐Weakness
- ☐Shortness of Breath
- ☐Decreased Endurance
- ☐Paralysis
- ☐Neurological Impairment
- ☐Amputation
- ☐Oxygen Use
- ☐Fine Motor Impairment
- ☐Poor Dentition
- ☐Tremors
- ☐Swallowing Problems
- ☐Choking
- ☐Aspiration

☐Tube Feeding

☐IV Feeding

#### **Supervision Need:**

- ☐Cognitive Impairment
- ☐Memory Impairment
- ☐Behavior Issues
- ☐Lack of Awareness
- ☐Difficulty Learning
- ☐Seizures

#### **Mental Health:**

- ☐Lack of Motivation/Apathy
- ☐Delusional
- ☐Hallucinations
- ☐Paranoia

**Comments:**

## LONG TERM CARE ELIGIBILITY ASSESSMENT: Supervision

## VII. SUPERVISION

**Definition:** The need for supervision is indicated by a significant impairment in Behavior and/or Cognition/Memory.

**A. Behaviors (Wandering/Disruptive/Self-Injurious/Resistive to care/Self-neglect)**

### Scoring Criteria:

- ☐0=The client demonstrates appropriate behavior; there is no concern.
- ☐1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The client may require redirection. Minimal intervention is needed.
- ☐2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client requires more than verbal redirection to interrupt inappropriate behaviors. The client needs medication assistance, monitoring, supervision or is unable to make safe decisions.
- ☐3=The client exhibits behaviors resulting in physical harm for self or others. The client requires extensive supervision to prevent physical harm to self or others.

**Due To: (Score must be justified through one or more of the following conditions)**

<p><b>Physical Impairments:</b></p> <p><input type="checkbox"/> Medication Management</p> <p><input type="checkbox"/> Chronic Medical Condition</p> <p><input type="checkbox"/> Acute Illness</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Neurological Impairment</p> <p><input type="checkbox"/> Choking</p> <p><input type="checkbox"/> Sensory Impairment</p> <p><input type="checkbox"/> Communication Impairment (not inability to speak English)</p> <p><b>Mental Health:</b></p> <p><input type="checkbox"/> Lack of Motivation/Apathy</p> <p><input type="checkbox"/> Delusional</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Paranoia</p> <p><input type="checkbox"/> Mood Instability</p> <p><b>Supervision needs:</b></p> <p><input type="checkbox"/> Short Term Memory Loss</p> <p><input type="checkbox"/> Long Term Memory Loss</p>	<p><input type="checkbox"/> Agitation</p> <p><input type="checkbox"/> Aggressive Behavior</p> <p><input type="checkbox"/> Cognitive Impairment</p> <p><input type="checkbox"/> Difficulty Learning</p> <p><input type="checkbox"/> Memory Impairment</p> <p><input type="checkbox"/> Verbal Abusiveness</p> <p><input type="checkbox"/> Constant Vocalization</p> <p><input type="checkbox"/> Sleep Deprivation</p> <p><input type="checkbox"/> Self-Injurious Behavior</p> <p><input type="checkbox"/> Impaired Judgment</p> <p><input type="checkbox"/> Disruptive to Others</p> <p><input type="checkbox"/> Disassociation</p> <p><input type="checkbox"/> Wandering</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Self Neglect</p>
--	---

**Comments:**

### **B. Memory/Cognition Deficit**

Scoring Criteria:

- ☐ 0= Independent no concern
- ☐ 1= The client can make safe decisions in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.
- ☐ 2= The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including medication assistance and monitoring or requires ongoing supervision or is unable to make safe decisions, or cannot make his/her basic needs known.
- ☐ 3= The client needs help most or all of time. Medications must be administered for the client.

**Due To: (Score must be justified through one or more of the following conditions)**

<p><b>Physical Impairments:</b></p> <p><input type="checkbox"/> Metabolic Disorder</p> <p><input type="checkbox"/> Medication Reaction</p> <p><input type="checkbox"/> Acute Illness</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Neurological Impairment</p> <p><input type="checkbox"/> Alzheimer's/Dementia</p> <p><input type="checkbox"/> Sensory Impairment</p> <p><input type="checkbox"/> Chronic Medical Condition</p> <p><input type="checkbox"/> Communication Impairment (does not include ability to speak English)</p> <p><input type="checkbox"/> Abnormal Oxygen Saturation</p> <p><input type="checkbox"/> Fine Motor Impairment</p> <p><b>Supervision Needs:</b></p> <p><input type="checkbox"/> Disorientation</p> <p><input type="checkbox"/> Cognitive Impairment</p> <p><input type="checkbox"/> Difficulty Learning</p> <p><input type="checkbox"/> Memory Impairment</p>	<p><input type="checkbox"/> Self-Injurious Behavior</p> <p><input type="checkbox"/> Impaired Judgment</p> <p><input type="checkbox"/> Unable to Follow Directions</p> <p><input type="checkbox"/> Constant Vocalizations</p> <p><input type="checkbox"/> Perseveration</p> <p><input type="checkbox"/> Receptive Expressive Aphasia</p> <p><input type="checkbox"/> Agitation</p> <p><input type="checkbox"/> Disassociation</p> <p><input type="checkbox"/> Wandering</p> <p><input type="checkbox"/> Lack of Awareness</p> <p><input type="checkbox"/> Seizures</p> <p><b>Mental Health:</b></p> <p><input type="checkbox"/> Lack of Motivation/Apathy</p> <p><input type="checkbox"/> Delusional</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Paranoia</p> <p><input type="checkbox"/> Mood Instability</p>
--	--

**Comments:**

## Assessment Demographics:

Location of Assessment:	Present at Interview:
<input type="checkbox"/> Applicant's private residence/home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital/other health care facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Agency Office <input type="checkbox"/> Relative's home <input type="checkbox"/> Other: _____	<input type="checkbox"/> Applicant Only <input type="checkbox"/> Caregiver(s) only <input type="checkbox"/> Applicant and caregiver(s) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Applicant and others

### Most of the interview information was provided by:

<input type="checkbox"/> Applicant <input type="checkbox"/> Caregiver <input type="checkbox"/> Applicant and Caregiver equally	<input type="checkbox"/> Medical record <input type="checkbox"/> Facility Staff <input type="checkbox"/> Other: _____
--	---

### Living Environment:

Safe	<input type="checkbox"/>	Services cannot be delivered here	<input type="checkbox"/>
Safe with feasible modifications	<input type="checkbox"/>	Client needs to move so services can be delivered	<input type="checkbox"/>
Services can be delivered here	<input type="checkbox"/>	Client needs to move to a safer environment	<input type="checkbox"/>
		Special home assessment needed	<input type="checkbox"/>

### Adult Protective Services Risk:

Person is known to be a current client of Adult Protective Services (APS) Yes ☐ No ☐

### Risk Evident During Assessment: (Check any that apply.)

<input type="checkbox"/> No risk factors or evidence of abuse or neglect apparent at this time. <input type="checkbox"/> The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid Significant negative health outcomes. <input type="checkbox"/> Risk factors present; however, LTC services may resolve issues. No APS referral being made at this time. <input type="checkbox"/> There are <u>statements of, or evidence of,</u> possible abuse, neglect, self-neglect, or financial exploitation.
--

☐ Referring to APS now? Yes ☐ No ☐

### Advance Directives and Legal Documents:

<input type="checkbox"/>	Living Will: _____
<input type="checkbox"/>	Power of Attorney  Financial Power of Attorney: _____  General Power of Attorney: _____  Medical Power of Attorney: _____
<input type="checkbox"/>	Conservator: _____
<input type="checkbox"/>	Guardian: _____

Comments/Narrative:

## LEVEL I IDENTIFICATION SCREEN FOR MENTAL ILLNESS/MENTAL RETARDATION

Instructions for completing this form are on reverse side of this page. WEB Page [www.cdhs.ctate.co.us/ohr/mhs/index.html](http://www.cdhs.ctate.co.us/ohr/mhs/index.html).

Client Name: \_\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Current Street Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State ZIP Code Current Location: \_\_\_\_\_  
Current Telephone Number: \_\_\_\_\_ Nursing Facility: \_\_\_\_\_

### SECTION I

#### PASRR/MI/Level I Screen

(See back of form for definitions)

1. Has a Major Mental Illness Diagnosis as on the back of this form? ☐ Yes ☐ No
2. Has a history of mental illness in the last 2 years? ☐ Yes ☐ No
3. Presents with symptoms of major mental illness (excluding primary dementia, substantiated by a neurological exam)? ☐ Yes ☐ No
4. Has been prescribed or routinely taken antipsychotic or antidepressant medication during the past 2 years? ☐ Yes ☐ No

List medications and diagnosis/es here:

#### Psychoactive Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### PASRR/MR-DD/Level I Screen

(See back of form for definitions)

1. MR-DD diagnosis. ☐ Yes ☐ No
2. Any history of mental retardation or developmental disability in the individual's past? ☐ Yes ☐ No
3. Presenting evidence of cognitive or behavioral impairment (before the age of 22) that may indicate that the individual has a developmental disability. ☐ Yes ☐ No
4. Referral by an agency that provides services to persons with mental retardation or developmental disabilities. ☐ Yes ☐ No

#### Diagnosis/es:

Note: If all responses to SECTION I are NO, skip to SECTION III.

### SECTION II

#### Individual Determinations - You must contact State Utilization Review Contractor and obtain clearance.

The individual meets: Date Authorized by URC Confirmation Number provided by State URC: (if applicable)  
A. Convalescent Criteria \_\_\_\_/\_\_\_\_/\_\_\_\_  
B. Severity of Illness Criteria \_\_\_\_/\_\_\_\_/\_\_\_\_  
C. Terminal Illness Criteria \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments:

### SECTION III

***To The Client/Legal Guardian: As a result of one or more "YES" responses on this screen, a more complete assessment may be necessary. This may result in a delay in the processing of your request for a nursing facility placement.***

Legal Guardian: ☐ Yes Date of duration \_\_\_\_/\_\_\_\_/\_\_\_\_ (If yes, please list the name and address below.)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Client / Legal Guardian has received a copy of this form: ☐ Yes ☐ No

To the Preparer of this form: By Federal Law, your signature is verification that a copy has been given to the client.

Printed Name of

Agency:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preparer: \_\_\_\_\_

Signature of

Telephone

Preparer: \_\_\_\_\_

Number: \_\_\_\_\_

**Note: Any "YES" response on this Level I Screen requires review by the Statewide Utilization Review Contractor.**

### SECTION I

Level I PASRR Screen: Both MI and MR-DD screens are completed if a client is accessing a nursing facility; do not complete for a Continued Stay review or HCBS EBD. All portions must be completed and a signature is required. If the determination by State URC differs from the responses submitted, instructions will be given to indicate the changes. Note that if there are any yes responses, a copy must be provided to the client and to the legal guardian if applicable, and that the required signature verifies that this has been done.

Note that the name and address of the client and legal guardian is required if there are any yes responses; by federal law the legal guardian and client must be notified, in writing, the findings of a Level I failure. Legal guardian definition: Court appointed including medical decision-making, not Power of Attorney (POA).

#### Level I / MI Instructions

1. Diagnosis of Mental Illness defined as: a diagnosis of a major mental disorder (as defined in the DSM-IV R) limited to **schizophrenia, paranoia, major affective including bipolar, major depression, dysthymia, cyclothymia or schizoaffective disorder or psychosis nos.**
2. Recent (2 year) history of mental illness and includes inpatient psychiatric hospitalization, mental health interventions or symptoms possibly related to mental illness.
3. Presenting evidence of mental illness: patient demonstrates symptomatology and/or behaviors characteristic of mental illness.
4. Use of psychotropic medications without an appropriate psychiatric diagnosis will require a yes response. List all psychotropic medications with corresponding diagnoses.

Any person who has a primary diagnosis of dementia that is based on a neurological examination is exempt from the PASRR process. This dementia exclusion **DOES NOT** apply to individuals with a diagnosis of mental retardation or major mental illness.

#### Level I / MR-DD

Developmental disability means:

A disability that is manifested before the person reaches twenty-two years of age, which constitutes a substantial handicap to the affected individual, and is attributable to mental

retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

## SECTION II

Individual determinations must be authorized by Statewide Utilization Review Contractor.

- A. Convalescent Care Criteria refers to discharge from hospital to NF for a prescribed stay of 60 days or less for rehab/convalescence for a medical or surgical condition that required hospitalization.
- B. Severity of Illness Criteria refers to a comatose, vent-dependent, vegetative state.
- C. Terminal Illness Criteria refers to physician documentation of life expectancy of less than 6 months.

## SECTION III

If the client fails or client requests a copy, the Level I, the client or legal guardian must receive a copy of this form by the referral source (signature verifies that this is done). Name and address must be provided so that a copy can be mailed to them. The above procedures are a requirement per federal regulations. The original copy is sent to the nursing facility. Copies as needed for client, guardian and Statewide Utilization Review Contractor.

Level of Care Determination								
Client Meets Level of Care						Yes <input type="checkbox"/> No <input type="checkbox"/>		
Activities of Daily Living Scores:								
	Bathing	Dressing	Toileting	Mobility	Transfers	Eating	Supervision Behaviors	Supervision Memory/Cognition
Scores:								
Is there documented medical information supporting any of the following programs? MI <input type="checkbox"/> BI <input type="checkbox"/> PLWA <input type="checkbox"/>							<b>Has Developmental Disability eligibility been determined?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
Comments/Supporting documentation:								

Services Requirements	
Waiver Services Needed within 30 Days	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Waitlist Waiver:
<i>If Waiver Services are not required within 30 days document referral to community resources:</i> Comments:	

Nursing Facility PASARR Determination	
PASARR Level 1 evaluation Completed <input type="checkbox"/>	Client Passed <input type="checkbox"/> Client Failed <input type="checkbox"/>
<input type="checkbox"/> Depression Diversion	Client Passed <input type="checkbox"/> Client Failed <input type="checkbox"/>
<input type="checkbox"/> Level II Evaluation Needed Referred to MHASA <input type="checkbox"/> Date	Referred to CCB <input type="checkbox"/> Date:
Comments:	

Long Term Care Certification																									
<input type="checkbox"/> Admission <input type="checkbox"/> CSR																									
SSN:                    -                    -	State ID:																								
Last Name:	First Name:	MI:	DOB:																						
County of Residence:		Date of Medicaid Application:																							
Facility Name:	Provider #:	Admit Date:																							
<b>DO NOT COMPLETE BELOW IF CLIENT IS APPROVED FOR WAITLIST</b>																									
<b style="text-align: center;">Target Group</b> <input type="checkbox"/> 1 Developmental Disability/MR <input type="checkbox"/> 2 Mental Health <input type="checkbox"/> 3 Frail Elderly (65+) <input type="checkbox"/> 4 Physically Disabled (18-64) <input type="checkbox"/> 5 Physically Disabled (13-17) <input type="checkbox"/> 6 Pediatric (<13) <input type="checkbox"/> 7 Brain Injury (16-64)	<b style="text-align: center;">Program Approval</b> <input type="checkbox"/> HCBS/DD (Comprehensive) <input type="checkbox"/> HCBS/MI <input type="checkbox"/> HCBS/EBD <input type="checkbox"/> HCBS/PLWA <input type="checkbox"/> Children's HCBS <input type="checkbox"/> Nursing Home <input type="checkbox"/> HCBS/BI <input type="checkbox"/> HCBS/CES <input type="checkbox"/> HCBS/BI Supported Living <input type="checkbox"/> PACE <input type="checkbox"/> ICF/MR <input type="checkbox"/> LTC- Skilled Home Health <input type="checkbox"/> HCBS/SLS <input type="checkbox"/> HCA <input type="checkbox"/> AFC	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="2" style="text-align: center; padding: 5px;">Certification Information</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">Confirmation #:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">Start Date:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">End Date:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">Authorized By:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">Agency</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">Authorization Date:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr style="background-color: #cccccc;"> <th colspan="2" style="text-align: center; padding: 5px;">Denial Information</th> </tr> <tr><td style="padding: 5px;">Date Denied:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">Date Denial Letter Mailed:</td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="padding: 5px;">Case Mgr. Initials</td><td style="border-bottom: 1px solid black;"></td></tr> </tbody> </table>		Certification Information		Confirmation #:		Start Date:		End Date:		Authorized By:		Agency		Authorization Date:		Denial Information		Date Denied:		Date Denial Letter Mailed:		Case Mgr. Initials	
Certification Information																									
Confirmation #:																									
Start Date:																									
End Date:																									
Authorized By:																									
Agency																									
Authorization Date:																									
Denial Information																									
Date Denied:																									
Date Denial Letter Mailed:																									
Case Mgr. Initials																									

## LONG TERM CARE ASSESSMENT FOR INSTRUMENTAL ACTIVITIES OF DAILY LIVING

### HYGIENE:

**Definition:** The ability to perform grooming, shaving, nail care, body care, oral care or hair care for the purpose of maintaining adequate hygiene.

### IADL SCORE CRITERIA

- ☐ 0=The client is independent in completing activity safely.
- ☐ 1=The client can manage their personal hygiene and grooming but must be reminded or supervised at least some of the time.
- ☐ 2=The client regularly requires verbal and/or hands on assistance with personal hygiene and grooming and cooperates in the process.
- ☐ 3=The client is dependent on others to provide all personal hygiene or grooming and/or is uncooperative with the process.

### Due To: (Score must be justified through one or more of the following conditions)

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> O2 Use	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Sensory Integration <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
--	---

**Comments:**

## MEDICATION MANAGEMENT:

**Definition:** The ability to follow prescribed medication regime.

### IADL SCORE CRITERIA

- ☐0=The client is Independent in completing activity safely.
- ☐1=The client is physically able to take medications but requires another person to (a) remind, monitor or observe the taking of medications less than daily; or (b) open a container, lay out or organize medications less than daily.
- ☐2=The client can physically take medications, but requires another person to either remind, monitor, or observe the taking of medications daily, or the client can physically take medications if another person daily opens containers, lays out, organizes medications.
- ☐3=The client cannot physically take medications and requires another person to assist and administer medications.

**Due To: (Score must be justified through one or more of the following conditions)**

#### Physical Deficits:

- ☐Pain  
☐Visually Impaired  
☐Limited Range of Motion  
☐Weakness  
☐Paralysis  
☐Neurological Deficit  
☐Fine Motor Deficit  
☐Communication Impairment (not inability to speak English)  
☐Swallowing  
☐Choking

#### Skilled Care:

- ☐Skilled Medication Administration (oral)  
☐Skilled Medication Administration (IV, parenteral, G tube)  
☐Skilled Medication Setup  
☐Medication Teaching  
☐Assess for side effects/ drug interactions  
☐Assess Medication Compliance

#### Supervision:

- ☐Cognitive Deficits  
☐Memory Impairment  
☐Behavior Issues  
☐Lack of Awareness  
☐Difficulty Learning  
☐Sensory Integration

#### Mental Health:

- ☐Lack of Motivation/Apathy  
☐Delusional  
☐Hallucinations  
☐Paranoia  
☐Mood Instability

**Comments:**

## Instrumental Activities of Daily Living (continued)

## TRANSPORTATION:

**Definition:** The ability to drive and/or access transportation services in the community.

### IADL SCORE CRITERIA

- ☐0=The client is independent in completing activity.
- ☐1=The client cannot drive or can drive but should not; or public transportation is not available.
- ☐2=The client requires assistance or supervision to arrange transportation but can use the transportation without assistance during the trip.
- ☐3=The client is totally dependent on being accompanied or helped by others during the trip and requires assistance to arrange transportation.

**Due To: (Score must be justified through one or more of the following conditions)**

#### Physical Deficits:

- ☐Pain  
☐Visually Impaired  
☐Hearing Impaired  
☐Limited Range of Motion  
☐Weakness  
☐Paralysis  
☐Neurological Deficit  
☐Fine Motor Deficit  
☐Communication Impairment (not inability to speak English)

#### Skilled Care:

- ☐Skilled Medical Accompaniment/Supervision

#### Supervision:

- ☐Cognitive Deficits  
☐Memory Impairment  
☐Behavior Issues  
☐Lack of Awareness  
☐Difficulty Learning

#### Mental Health:

- ☐Lack of Motivation/Apathy  
☐Delusional  
☐Hallucinations  
☐Paranoia  
☐Mood Instability

**Comments:**

**MONEY MANAGEMENT:**

**Definition:** The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle coins and paper work, i.e. to do financial management for basic necessities (food, clothing, shelter). Do not check if limitation is only cultural (e.g., recent immigrant who has not learned U.S. currency and/or English language).

**IADL SCORE CRITERIA**

- ☐0=The client is independent in completing activity.  
☐1=The client requires cueing and/or supervision. May need minimal physical assistance.  
☐2=The client requires assistance in budgeting, paying bills, planning, writing checks or money orders and related paperwork. Client has the ability to manage small amounts of discretionary money without assistance.  
☐3=The client is totally dependent on others for all financial transactions and money handling.

**Due To: (Score must be justified through one or more of the following conditions)**

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
---	---

**Comments:**

## Instrumental Activities of Daily Living (continued)

### SHOPPING:

**Definition:** The ability to run errands and shop; select appropriate items, get around in a store, physically acquire, transport and put away items (money management not considered in this activity).

#### IADL SCORE CRITERIA

- ☐0=The client is independent in completing activity.
- ☐1=The client is physically able to shop but needs prompts/cueing to initiate task.
- ☐2=The client requires accompaniment and verbal cues, and/or physical assistance during the activity.
- ☐3=The client is totally dependent on others to do essential shopping.

**Due To: (Score must be justified through one or more of the following conditions)**

<u>Physical Deficits:</u> <ul style="list-style-type: none"><li><input type="checkbox"/>Pain</li><li><input type="checkbox"/>Visually Impaired</li><li><input type="checkbox"/>Hearing Impaired</li><li><input type="checkbox"/>Limited Range of Motion</li><li><input type="checkbox"/>Decreased Endurance</li><li><input type="checkbox"/>Falls</li><li><input type="checkbox"/>Balance</li><li><input type="checkbox"/>Weakness</li><li><input type="checkbox"/>Paralysis</li><li><input type="checkbox"/>Neurological Deficit</li><li><input type="checkbox"/>Fine Motor Deficit</li><li><input type="checkbox"/>Communication Impairment (not inability to speak English)</li></ul>	<u>Supervision:</u> <ul style="list-style-type: none"><li><input type="checkbox"/>Cognitive Deficits</li><li><input type="checkbox"/>Memory Impairment</li><li><input type="checkbox"/>Impaired Judgment</li><li><input type="checkbox"/>Behavior Issues</li><li><input type="checkbox"/>Lack of Awareness</li><li><input type="checkbox"/>Difficulty Learning</li></ul> <u>Mental Health:</u> <ul style="list-style-type: none"><li><input type="checkbox"/>Lack of Motivation/Apathy</li><li><input type="checkbox"/>Delusional</li><li><input type="checkbox"/>Hallucinations</li><li><input type="checkbox"/>Paranoia</li><li><input type="checkbox"/>Mood Instability</li></ul>
--	--

**Comments:**

### MEAL PREPARATION:

**Definition:** The ability to obtain and prepare routine meals. This includes the ability to independently open containers and use kitchen appliances, with assistive devices if person uses them. If the person is fed via tube feedings or intravenously, treat preparation of the tube feeding as meal preparation and indicate level of help needed.

#### IADL SCORE CRITERIA

- ☐0=The client is independent in completing activity.
- ☐1=The client requires some instruction or physical assistance to prepare meals.
- ☐2=The client can participate but needs substantial assistance to prepare meals.
- ☐3=The client cannot prepare or participate in preparation of meals.

**Due To: (Score must be justified through one or more of the following conditions)**

<u>Physical Deficits:</u> <ul style="list-style-type: none"><li><input type="checkbox"/>Pain</li><li><input type="checkbox"/>Visually Impaired</li><li><input type="checkbox"/>Hearing Impaired</li><li><input type="checkbox"/>Limited Range of Motion</li><li><input type="checkbox"/>Decreased Endurance</li><li><input type="checkbox"/>Falls</li><li><input type="checkbox"/>Balance</li><li><input type="checkbox"/>Weakness</li><li><input type="checkbox"/>Paralysis</li><li><input type="checkbox"/>Neurological Deficit</li><li><input type="checkbox"/>Fine Motor Deficit</li><li><input type="checkbox"/>Communication Impairment (not inability to speak English)</li></ul>	<u>Supervision:</u> <ul style="list-style-type: none"><li><input type="checkbox"/>Cognitive Deficits</li><li><input type="checkbox"/>Memory Impairment</li><li><input type="checkbox"/>Impaired Judgment</li><li><input type="checkbox"/>Behavior Issues</li><li><input type="checkbox"/>Lack of Awareness</li><li><input type="checkbox"/>Difficulty Learning</li></ul> <u>Mental Health:</u> <ul style="list-style-type: none"><li><input type="checkbox"/>Lack of Motivation/Apathy</li><li><input type="checkbox"/>Delusional</li><li><input type="checkbox"/>Hallucinations</li><li><input type="checkbox"/>Paranoia</li><li><input type="checkbox"/>Mood Instability</li></ul>
--	--

**Comments:**

## Instrumental Activities of Daily Living (continued)

### LAUNDRY:

**Definition:** The ability to maintain cleanliness of personal clothing and linens.

#### IADL SCORE CRITERIA

- ☐0=Independent in completing activity.
- ☐1=The client is physically capable of using laundry facilities, but requires cueing and/or supervision.
- ☐2=The client is not able to use laundry facilities without physical assistance.
- ☐3=The client is dependent upon others to do all laundry.

**Due To: (Score must be justified through one or more of the following conditions)**

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
--	---

**Comments:**

### ACCESSING RESOURCES:

**Definition:** The ability to identify needs and locate appropriate resources; is able to complete phone calls, setup and follow through with appointments and to complete paperwork necessary to acquire/participate in service/activity offered by the resource.

#### IADL SCORE CRITERIA

- ☐0=The client is independent in completing activity.
- ☐1=The client is capable with minimal prompts or cues to complete some of the tasks associated with accessing resources.
- ☐2=The client requires substantial prompts/cues or physical assistance to complete most of the tasks associated with accessing resources.
- ☐3=The client is totally dependent upon others to access resources and follow through with appointments.

**Due To: (Score must be justified through one or more of the following conditions)**

<u>Physical Deficits:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Balance <input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Deficit <input type="checkbox"/> Fine Motor Deficit <input type="checkbox"/> Communication Impairment (not inability to speak English)	<u>Supervision:</u> <input type="checkbox"/> Cognitive Deficits <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
--	---

**Comments:**

## Instrumental Activities of Daily Living (continued)

### HOUSEWORK:

**Definition:** The ability to maintain cleanliness of the living environment.

### IADL SCORE CRITERIA

☐0=The client is independent in completing activity.

☐1=The client is physically capable of performing essential housework tasks but requires minimal prompts/cues or supervision to complete essential housework tasks.

☐2=The client requires substantial prompts/cues or supervision and/or physical assistance to complete essential housework tasks. The client may be able to perform some housekeeping tasks but may require another person to complete heavier cleaning tasks.

☐3=The client is dependent upon others to do all housework in client use area.

**Due To: (Score must be justified through one or more of the following conditions)**

#### Physical Deficits:

- ☐Pain
- ☐Visually Impaired
- ☐Hearing Impaired
- ☐Limited ROM
- ☐Decreased Endurance
- ☐Falls
- ☐Balance
- ☐Weakness
- ☐Paralysis
- ☐Neurological Deficit
- ☐Fine Motor Deficit
- ☐Communication Impairment (not inability to speak English)

#### Supervision:

- ☐Cognitive Deficits
- ☐Memory Impairment
- ☐Impaired Judgment
- ☐Behavior Issues
- ☐Lack of Awareness
- ☐Difficulty Learning

#### Mental Health:

- ☐Lack of Motivation/Apathy
- ☐Delusional
- ☐Hallucinations
- ☐Paranoia
- ☐Mood Instability

**Comments:**

## Strengths Assessment and Evaluation

**Please identify strengths in each domain:**

SOCIAL SUPPORTS	PARTICIPATION IN ACTIVITIES	EXTERNAL RESOURCES	HEALTH AND WELLNESS	PERSONAL ASSETS
<input type="checkbox"/> Supportive family <input type="checkbox"/> Supportive friends <input type="checkbox"/> Caring neighbors <input type="checkbox"/> Community recognition and respect <input type="checkbox"/> Sense of a place in the world <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Creative activities <input type="checkbox"/> Church/spiritual activities <input type="checkbox"/> Community activities <input type="checkbox"/> Clubs, groups, planned meetings <input type="checkbox"/> Volunteer service opportunities <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adequate housing <input type="checkbox"/> Financial security <input type="checkbox"/> Adequate transportation <input type="checkbox"/> Safe environment <input type="checkbox"/> Access to safety resources <input type="checkbox"/> Medical equipment <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adequate physical health <input type="checkbox"/> Balanced mental health <input type="checkbox"/> Self care ability or resources <input type="checkbox"/> Adequate medical access <input type="checkbox"/> Commitment to health <input type="checkbox"/> Knowledge about how choices impact health  <input type="checkbox"/> Other: _____  <input type="checkbox"/> Other: _____	<input type="checkbox"/> Positive self-image <input type="checkbox"/> sense of empowerment <input type="checkbox"/> positive view of others <input type="checkbox"/> positive view of the future <input type="checkbox"/> adequate communication skills <input type="checkbox"/> sense of purpose <input type="checkbox"/> ability to ask for and accept help <input type="checkbox"/> ability to accept personal responsibility <input type="checkbox"/> other: _____  <input type="checkbox"/> other: _____

### LIST STRENGTHS / ASSETS THREATENED OR RECENTLY WEAKENED

STRENGTH / ASSET	WHY WEAKENED OR THREATENED?

### LIST STRENGTHS CLIENT WOULD LIKE TO INCREASE OR ADD TO A DOMAIN

STRENGTH:	HOW COULD THIS BE INCREASED OR ADDED?	WHO WILL TAKE THE FIRST STEP?

## Self Reported Physical Health

### Medical Treatments or Therapy Regimes:

Services Needed:					
Skilled	N	R	Freq	D/W/M	Provider Name
Blood sugar monitoring	<input type="checkbox"/>	<input type="checkbox"/>			
Bowel/Bladder program	<input type="checkbox"/>	<input type="checkbox"/>			
Catheter care	<input type="checkbox"/>	<input type="checkbox"/>			
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>			
Foot Care	<input type="checkbox"/>	<input type="checkbox"/>			
Injections	<input type="checkbox"/>	<input type="checkbox"/>			
IV Therapies	<input type="checkbox"/>	<input type="checkbox"/>			
Medication monitor	<input type="checkbox"/>	<input type="checkbox"/>			
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>			
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>			
Ostomy care	<input type="checkbox"/>	<input type="checkbox"/>			
Physical therapy regime	<input type="checkbox"/>	<input type="checkbox"/>			
Range of motion	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory treatment	<input type="checkbox"/>	<input type="checkbox"/>			
Speech therapy regime	<input type="checkbox"/>	<input type="checkbox"/>			
Suctioning	<input type="checkbox"/>	<input type="checkbox"/>			
Tube Feeding	<input type="checkbox"/>	<input type="checkbox"/>			
Ventilator Assistance	<input type="checkbox"/>	<input type="checkbox"/>			
Wound care/Dressing	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Comments:</b>
------------------

### Psycho/Social Health:

Support Systems:	Caregiver?	Phone:	Contacted?
<input type="checkbox"/> Spouse:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Friends:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Family:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Neighbor:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Faith Based Name:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Support Group:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Agency/ Organization:	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Community Based:	<input type="checkbox"/>		<input type="checkbox"/>

Psycho/Social Problems:	
<input type="checkbox"/> Psychological illness present	<b>Significant Changes</b>
<input type="checkbox"/> Psychological illness history	<b>Losses</b>
<input type="checkbox"/> Depression	<input type="checkbox"/> Death of spouse
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Death of friend/family member
<input type="checkbox"/> Crying	<input type="checkbox"/> Death of pet
<input type="checkbox"/> Insomnia	<b>Changes</b>
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Change in residence <input type="checkbox"/> Divorce/separation <input type="checkbox"/> Retirement

<input type="checkbox"/> Loss of appetite <input type="checkbox"/> Concerns regarding potential psychosocial situation <input type="checkbox"/> Poor eye contact <input type="checkbox"/> Alcohol/Substance Abuse	<b>Threat/Victim</b> <input type="checkbox"/> Financial concern <input type="checkbox"/> Safety concerns <input type="checkbox"/> Victim of assault/theft <input type="checkbox"/> Victim of abuse/neglect
--	--

## LONG TERM CARE PLAN

Non-Medicaid Services Available to Address Needs			
Service	Provider	Frequency and Duration	Availability

### Medicaid Services

Equipment:	Have	Need	Equipment:	Have	Need
Adaptive Seating	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent Catheter	<input type="checkbox"/>	<input type="checkbox"/>
Adaptive Utensils	<input type="checkbox"/>	<input type="checkbox"/>	IV Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	Kitchen Access	<input type="checkbox"/>	<input type="checkbox"/>
Augmentative Communication Device	<input type="checkbox"/>	<input type="checkbox"/>	Lift chair Manual Lift	<input type="checkbox"/>	<input type="checkbox"/>
Bath Mat	<input type="checkbox"/>	<input type="checkbox"/>	Mechanical Lift	<input type="checkbox"/>	<input type="checkbox"/>
Bath/Shower Chair	<input type="checkbox"/>	<input type="checkbox"/>	Medication Box	<input type="checkbox"/>	<input type="checkbox"/>
Bathroom Access	<input type="checkbox"/>	<input type="checkbox"/>	Medication Dispenser	<input type="checkbox"/>	<input type="checkbox"/>
Braces	<input type="checkbox"/>	<input type="checkbox"/>	Monitors	<input type="checkbox"/>	<input type="checkbox"/>
Cane	<input type="checkbox"/>	<input type="checkbox"/>	Orthotics	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Stockings	<input type="checkbox"/>	<input type="checkbox"/>	Ostomy Supplies	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning Equipment	<input type="checkbox"/>	<input type="checkbox"/>	Pivot Board	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning Supplies	<input type="checkbox"/>	<input type="checkbox"/>	Plate Guard	<input type="checkbox"/>	<input type="checkbox"/>
Commode	<input type="checkbox"/>	<input type="checkbox"/>	Protheses	<input type="checkbox"/>	<input type="checkbox"/>
Crutches	<input type="checkbox"/>	<input type="checkbox"/>	Ramp	<input type="checkbox"/>	<input type="checkbox"/>
Electric Lift	<input type="checkbox"/>	<input type="checkbox"/>	Reacher	<input type="checkbox"/>	<input type="checkbox"/>
Electronic Monitor	<input type="checkbox"/>	<input type="checkbox"/>	Roll-In Shower	<input type="checkbox"/>	<input type="checkbox"/>
External Catheter	<input type="checkbox"/>	<input type="checkbox"/>	Scooter	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Pump	<input type="checkbox"/>	<input type="checkbox"/>	Sliding Board	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Sock Aide	<input type="checkbox"/>	<input type="checkbox"/>
Foley Catheter	<input type="checkbox"/>	<input type="checkbox"/>	Standing Frame	<input type="checkbox"/>	<input type="checkbox"/>
Gait Belt	<input type="checkbox"/>	<input type="checkbox"/>	Transfer Bench	<input type="checkbox"/>	<input type="checkbox"/>
Grab Bars	<input type="checkbox"/>	<input type="checkbox"/>	Urinal	<input type="checkbox"/>	<input type="checkbox"/>
Hand Held Shower	<input type="checkbox"/>	<input type="checkbox"/>	Walker	<input type="checkbox"/>	<input type="checkbox"/>
Handrail	<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Hi Riser	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

N = Needs  
 R =  
 Receiving  
 D/W/M =  
 Daily,  
 Weekly,  
 Monthly

Skilled Medicaid Services						
Skilled	N	R	Freq	D/W/M	Provider Name	Task to be completed
CNA	<input type="checkbox"/>	<input type="checkbox"/>				
LPN	<input type="checkbox"/>	<input type="checkbox"/>				
RN	<input type="checkbox"/>	<input type="checkbox"/>				
Psych RN	<input type="checkbox"/>	<input type="checkbox"/>				
Self	<input type="checkbox"/>	<input type="checkbox"/>				
Family	<input type="checkbox"/>	<input type="checkbox"/>				
Unpaid Provider	<input type="checkbox"/>	<input type="checkbox"/>				
Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>				
PT	<input type="checkbox"/>	<input type="checkbox"/>				
OT	<input type="checkbox"/>	<input type="checkbox"/>				
RT	<input type="checkbox"/>	<input type="checkbox"/>				
ST	<input type="checkbox"/>	<input type="checkbox"/>				
Ambulance	<input type="checkbox"/>	<input type="checkbox"/>				

**Comments:**

Unskilled Medicaid Services							
Unskilled	N	R	Freq	D/W/M	Provider Name	Tasks to be completed	
ACF/AFC	<input type="checkbox"/>	<input type="checkbox"/>					
ADC	<input type="checkbox"/>	<input type="checkbox"/>					
Counselor	<input type="checkbox"/>	<input type="checkbox"/>					
EM	<input type="checkbox"/>	<input type="checkbox"/>					
Family	<input type="checkbox"/>	<input type="checkbox"/>					
Home Care Provider	<input type="checkbox"/>	<input type="checkbox"/>					
Home Mod	<input type="checkbox"/>	<input type="checkbox"/>					
Homemaker	<input type="checkbox"/>	<input type="checkbox"/>					
ILST	<input type="checkbox"/>	<input type="checkbox"/>					
Med. Transport.	<input type="checkbox"/>	<input type="checkbox"/>					
Medication Dispense	<input type="checkbox"/>	<input type="checkbox"/>					
Non-Med. Transport.	<input type="checkbox"/>	<input type="checkbox"/>					
PCP	<input type="checkbox"/>	<input type="checkbox"/>					
Pest Control	<input type="checkbox"/>	<input type="checkbox"/>					
Self	<input type="checkbox"/>	<input type="checkbox"/>					
Unpaid	<input type="checkbox"/>	<input type="checkbox"/>					
Voc. Rehab	<input type="checkbox"/>	<input type="checkbox"/>					

**Comments:**

## ATTACHMENT F -1

LOC: ICF/MR

Demonstration of Waiver service cost estimates:

**Amended 06/2003**Waiver Year 1 07/03-6/04 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

Waiver Service	#Undup. Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Assistance Services	72	700	\$13.36	\$673,344
Environmental Engineering Services	50	4	\$458	\$91,600
Specialized Medical Equipment	17	5	\$155	\$13,175
Professional Services	42	50	\$66	\$138,600
Community Connection	60	288	\$13.36	\$230,861
GRAND TOTAL (sum of Column E) :				\$1,147,580
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				74
Waiver Cost estimate (Divide total by number of recipients):				\$15,508
AVERAGE LENGTH OF STAY: <u>365</u>				

## ATTACHMENT F -2

LOC: ICF/MR

Demonstration of Waiver Cost estimates:

**Amended 06/2003**Waiver Year 1 \_\_\_\_\_ 2 7/04-6/05 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

Waiver Service	#Undup. Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Assistance Services	72	700	\$13.56	\$683,424
Environmental Engineering Services	50	4	\$465	\$93,000
Specialized Medical Equipment	17	5	\$157	\$13,345
Professional Services	42	50	\$67	\$140,700
Community Connection	60	288	\$13.56	\$234,317
GRAND TOTAL (sum of Column E) :				\$1,164,786
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				74
Waiver Cost estimate (Divide total by number of recipients):				\$15,740
AVERAGE LENGTH OF STAY: <u>365</u>				

## ATTACHMENT F -3

LOC: ICF/MR

Demonstration of Waiver Cost estimates:

**Amended 06/2003**Waiver Year 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 7/05-6/06 4 \_\_\_\_\_ 5 \_\_\_\_\_

Waiver Service	#Undup. Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Assistance Services	72	700	\$13.76	\$693,504
Environmental Engineering Services	50	4	\$472	\$94,400
Specialized Medical Equipment	17	5	\$159	\$13,515
Professional Services	42	50	\$68	\$142,800
Community Connection	60	288	\$13.76	\$237,773
GRAND TOTAL (sum of Column E) :				\$1,181,992
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				74
Waiver Cost estimate (Divide total by number of recipients):				\$15,973
AVERAGE LENGTH OF STAY: <u>365</u>				

## ATTACHMENT F -4

LOC: ICF/MR

Demonstration of Waiver Cost estimates:

**Amended 06/2003**Waiver Year 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 7/06-6/07 5 \_\_\_\_\_

Waiver Service	#Undup. Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Assistance Services	72	700	\$13.97	\$704,088
Environmental Engineering Services	50	4	\$479	\$95,800
Specialized Medical Equipment	17	5	\$161	\$13,685
Professional Services	42	50	\$69	\$144,900
Community Connection	60	288	\$13.97	\$241,402
GRAND TOTAL (sum of Column E) :				\$1,199,875
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				74
Waiver Cost estimate (Divide total by number of recipients):				\$16,215
AVERAGE LENGTH OF STAY: <u>365</u>				

## ATTACHMENT F -5

LOC: ICF/MR

Demonstration of Waiver Cost estimates:

**Amended 06/2003**Waiver Year 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 7/07-6/08

Waiver Service	#Undup. Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Assistance Services	72	700	\$14.18	\$714,672
Environmental Engineering Services	50	4	\$486	\$97,200
Specialized Medical Equipment	17	5	\$163	\$13,855
Professional Services	42	50	\$70	\$147,000
Community Connection	60	288	\$14.18	\$245,030
GRAND TOTAL (sum of Column E) :				\$1,217,757
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				74
Waiver Cost estimate (Divide total by number of recipients):				\$16,456
AVERAGE LENGTH OF STAY: <u>365</u>				

ATTACHMENT F-6

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

**YEAR 1**

FACTOR D:	<u>\$ 15,508</u>	FACTOR G:	<u>\$121,459</u>
FACTOR D':	<u>\$ 27,051</u>	FACTOR G':	<u>\$ 4,388</u>
TOTAL:	<u>\$ 42,559</u>	≤	TOTAL: <u>\$125,847</u>

**YEAR 2**

FACTOR D:	<u>\$ 15,740</u>	FACTOR G:	<u>\$125,103</u>
FACTOR D':	<u>\$ 27,457</u>	FACTOR G':	<u>\$ 4,476</u>
TOTAL:	<u>\$ 43,197</u>	≤	TOTAL: <u>\$129,579</u>

**YEAR 3**

FACTOR D:	<u>\$ 15,973</u>	FACTOR G:	<u>\$128,856</u>
FACTOR D':	<u>\$ 27,869</u>	FACTOR G':	<u>\$ 4,566</u>
TOTAL:	<u>\$ 43,842</u>	≤	TOTAL: <u>\$133,422</u>

**YEAR 4**

FACTOR D:	<u>\$ 16,215</u>	FACTOR G:	<u>\$132,722</u>
FACTOR D':	<u>\$ 28,287</u>	FACTOR G':	<u>\$ 4,657</u>
TOTAL:	<u>\$ 44,502</u>	≤	TOTAL: <u>\$137,379</u>

**YEAR 5**

FACTOR D:	<u>\$ 16,456</u>	FACTOR G:	<u>\$136,704</u>
FACTOR D':	<u>\$ 28,711</u>	FACTOR G':	<u>\$ 4,750</u>
TOTAL:	<u>\$ 45,167</u>	≤	TOTAL: <u>\$141,454</u>